DO NOT STAPLE IN THIS AREA			0	Private Periodic Immuniza	Screeni	ng						
PICA				HEALTH IN	SURANCE C	LAII	и FO	RM		PICA		
MEDICARE MEDICAL (Medicare #) (Medicaid	CHAMP		AMPVA GROUP HEALTH PLAN (SSN or ID)	FECA OTHE BLK LUNG (SSN) (ID)	90000000000000000000000000000000000000		3		(FOR P	ROGRAM IN ITE		
2. PATIENT'S NAME (Last Name			13. PATIENT'S BIRTH DAT	E SEX	4. INSURED'S NAME		ame, Firs	st Name,	, Middle	Initial)		
Brown, Charlie 5. PATIENT'S ADDRESS (No., S	reet)		6 PATIENT RELATIONS	M X F	7. INSURED'S ADDR	DESC /N/	Street	,				
11 Peanut Lane	iecij			Child Other	7. INSURED S ADDR	TESS (INC)., Street)	,				
Raleigh			NC Single Marie	od Other	CITY					STATE		
ZIP CODE	TELEPHONE (In	nclude Area Code)			ZIP CODE		TEL	EPHON	E (INCL	UDE AREA COD		
9. OTHER INSURED'S NAME (LE	· · · · · · · · · · · · · · · · · · ·	55–1212	Employed Full-Tin Studen	Student	11. INSURED'S POL	icy coc	VIB OB 5	()			
9. OTHER INSURED'S NAME (LE	ist Name, First Na	me, Middle Initial)	10. IS PATIENT S CONDI	HON HELATED TO.	11. INSURED S POL	ICY GHC	JUP OH F	-ECA NI	DWRFH			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S DATE OF BIRTH SEX					
b. OTHER INSURED'S DATE OF	BIRTH S	SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAM	ME OR S	CHOOL I		-			
c. EMPLOYER'S NAME OR SCH	M	F	c. OTHER ACCIDENT?	NO	c. INSURANCE PLAN	I NAME	OB PBC	GRAMA	JAME			
C. EIN ESTEITS WANTE STOOT	SOC WANTE		YES	NO	C. INSUPANCE FEAT	A NAME	On r not	OHAW N	(AWIL			
d. INSURANCE PLAN NAME OR	PROGRAM NAME	E	10d. RESERVED FOR LO	10d. RESERVED FOR LOCAL USE			TH BEN					
					YES	NO	If yes,	return to	and co	mplete item 9 a-		
			ETING & SIGNING THIS FORM.	or information passages				SON'S	SIGNA	TURE I authorize		
12. PATIENT'S OR AUTHORIZED	PERSON'S SIGN	NATURE I authori	.ETING & SIGNING THIS FORM. ize the release of any medical or oth s either to myself or to the party who	er information necessary accepts assignment	payment of medic services described	al benefit		SON'S	SIGNA			
 PATIENT'S OR AUTHORIZED to process this claim. I also req 	PERSON'S SIGN	NATURE I authori	ize the release of any medical or oth	er information necessary accepts assignment	payment of medic	al benefit		SON'S	SIGNA			
12. PATIENT'S OR AUTHORIZED to process this claim. I also red below. SIGNED 14. DATE OF CURRENT: MM DD YY IN PR	D PERSON'S SIGN uest payment of go UESS (First symp URY (Accident) C UEGNANCY(LMP)	NATURE I authori overnment benefits otom) OR	ize the release of any medical or oth s either to myself or to the party who	accepts assignment E OR SIMILAR ILLNESS.	payment of medic services described SIGNED 16. DATES PATIENT FROM DI	UNABLE	s to the u	RSON'S undersign RK IN CI TO	SIGNATION OF THE PROPERTY OF T	T OCCUPATION		
12 PATIENT'S OR AUTHORIZED to process this claim. I also requebelow. SIGNED 14. DATE OF CURRENT: MM DD Y	PERSON'S SIGI uest payment of go NESS (First symp JURY (Accident) C IEGNANCY(LMP) IICIAN OR OTHER	NATURE I authori overnment benefits otom) OR DR R SOURCE	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE 17a. I.D. NUMBER OF REFERR	accepts assignment F OR SIMILAR ILLNESS. The High High High High High High High High	payment of medic services described SIGNED 18. DATES PATIENT FROM 18. HOSPITALIZATIO FROM DI FROM D	UNABLED YY NO YY	TO WOR	RSON'S undersign RK IN CI TO	SIGNA' ned phy URREN MM CURREI MM	T OCCUPATION		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: MM D YY 17. NAME OF REFERRING PHYS 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF	PERSON'S SIGI uest payment of go NESS (First symp JURY (Accident) C IEGNANCY(LMP) IICIAN OR OTHER	NATURE I authori overnment benefits otom) OR DR R SOURCE	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT THAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY	accepts assignment F OR SIMILAR ILLNESS. The High High High High High High High High	payment of medic-services described SIGNED 16. DATES PATIENT FROM DI 18. HOSPITALIZATIO FROM DI 20. OUTSIDE LAB?	UNABLED YY NO DATE:	TO WOR	RK IN CI TO TO	URREN MM :	T OCCUPATION		
12 PATIENT'S OR AUTHORIZET to process this claim. I also requebelow. SIGNED 14. DATE OF CURRENT: MM DD Y NEW PF 17. NAME OF REFERRING PHYS 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF 1. LYZQL 2.	PERSON'S SIGI uest payment of go NESS (First symp JURY (Accident) C IEGNANCY(LMP) IICIAN OR OTHER	NATURE I authori overnment benefits otom) OR DR R SOURCE	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE 17a. I.D. NUMBER OF REFERR	accepts assignment F OR SIMILAR ILLNESS. The High High High High High High High High	payment of medic-services described SIGNED 16. DATES PATIENT FROM DI 18. HOSPITALIZATIO FROM 20. OUTSIDE LAB? 29. MEDICAID BESUIE	UNABLE D YY NO BMISSIO	TO WOR	RK IN CI TO ED TO S CHAF	URREN MM :	T OCCUPATION		
12 PATIENT'S OR AUTHORIZED to process this claim. I also requebew. SIGNED 14 DATE OF CURRENT: MM DD YY LL LL LL LL LL LL	PERSON'S SIGN uest payment of go NESS (First symp IUEN' (Ficial symp I	NATURE authoriovernment benefits Norm) OR R SOURCE URY. (RELATE IT	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE 17a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	accepts assignment E OR SIMILAR ILLNESS. D	payment of medic services described SIGNED 16. DATES PATIENT FROM 18. HOSPITALIZATIO FROM 20. OUTSIDE LAB? YES 22. MEDICAID RESUI	UNABLE YY IN DATE: NO BMISSIO	TO WOR	RK IN CI TO ED TO S CHAF	URREN MM :	T OCCUPATION DD : YY TO SERVICES DD : YY		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: LILY MM DD Y LILY MM DD Y LILY PP 17. NAME OF REFERRING PHYS 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF 1. LYZOL . 2. 2. L	PERSON'S SIGN uest payment of go NESS (First symp UERY (Forst ent) UERY (NATURE author overnment benefits Notom) OR R SOURCE URY (RELATE IT	ze the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT THAS HAD SAMI GIVE FIRST DATE 117a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	accepts assignment E OR SIMILAR ILLNESS. D	payment of medic services described SIGNED 16. DATES PATIENT FROM MM DI 18. HOSPITALIZATIO FROM MM DI 20. OUTSIDE LAB? YES 22. MEDICAID RESUL CODE 23. PRIOR AUTHORIZ	UNABLE OF YY NO BMISSIO ZATION G DAYS OR	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM :	T OCCUPATION DD YY NT SERVICES DD YY		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: MM DD Y LL LL LL LL LL LL	PERSON'S SIGN uest payment of go NESS (First symp UERY (Acident) O EGMANCY(LMP) ILLNESS OR INJI ILLNESS OR INJI To Plac To DD YY Serv.	NATURE author overnment benefits Storm) OR R SOURCE URY (RELATE IT C C Or Type PROC oricle Service CPT.	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described SIGNED 16. DATES PATIENT FROM MM DI 18. HOSPITALIZATIO FROM MM DI 20. OUTSIDE LAB? 22. MEDICAID RESUL CODE 23. PRIOR AUTHORIZ	UNABLE OF YY NO BMISSIO ZATION G DAYS OR	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: MM DD Y LL MM DD Y MM LL MM DD Y MM	PERSON'S SIGN uest payment of go NESS (First symp IURY (Accident) C EGNANCY(LMP) elician OR OTHER ILLNESS OR INJU To Plac DD YY Serv 0 02 11	NATURE I authoriovernment benefits Storn) OR DR R SOURCE URY. (RELATE IT DE Type PROCE COT Type PROCE COT Type PROCE Service Service CPT.	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE MY 17. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described SIGNED 16. DATES PATIENT FROM MM DI 18. HOSPITALIZATIO FROM MM DI 20. OUTSIDE LAB? 22. MEDICAID RESUL CODE 23. PRIOR AUTHORI; \$ CHARGES	UNABLE DYYY NO DATE: NO BMISSIO ZATION G DAYS UNITS	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14. DATE OF CURRENT: LLL MM DD YY LLL MM DD YY LLL MM PP 17. NAME OF REFERRING PHYS 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF LLV20. 2. 22. LLL MM DD YY MM 12. 10 O2 12 10	PERSON'S SIGNUEST PARTIES SYMPONIES (First symponies) URSY (Accident) O EGMANCY (LMP) ICLAN OR OTHER PLANT OF TO DD YY SERV D O O 111	NATURE I authorioveriment benefits Storm) OR R SOURCE URY (RELATE IT C Type PROC CPT Coal Service CPT 9 9	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described SIGNED 16. DATES PATIENT FROM 18. HOSPITALIZATIO FROM 20. OUTSIDE LAB? YES 22. MEDICAID RESUL CODE 5 CHARGES 80. 33	UNABLE TO A TO	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION DD 1 YY NT SERVICES DD 1 YY K RESERVED F(
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: LINE MM 1 DD 1 YY 17. NAME OF REFERRING PHYS 19. RESERVED FOR LOCAL USE 21. DIAGNOSIS OR NATURE OF 1. LVZQL 2. 22. 24. A	PERSON'S SIGNUEST PARTIES AND PARTIES OF INJURY (Accident) C EGNANCY (LMP) IIILINESS OF INJURY (ACCIDENT) AND PROPERTY OF THE	NATURE authoriovernment benefits Storm) OR R SOURCE URY. (RELATE IT C C Type PROCE Solice Service CPT. 90	ze the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE 117a. I.D. NUMBER OF REFERR EMS 1.2.3 OR 4 TO ITEM 24E BY 3. L	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described SIGNED 16. DATES PATIENT FROM MM DO 18. HOSPITALIZATIO FROM LO 20. OUTSIDE LAB? 22. MEDICAID RESULCODE 23. PRIOR AUTHORIZ F \$ CHARGES 80. 33 13. 71	UNABLE UN	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14. DATE OF CURRENT: ILL IL	PERSON'S SIGN uest payment of go NESS (First symp IURY (Accident) C EGNANCY(LMP) sician OR OTHER To Plate To Plate To Plate Serv D 02 11 D 02 11 D 02 11	NATURE authoriovernment benefits Storm) OR	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE MM ITEM STATE AND SAM ITEM SAM IT	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described SIGNED 16. DATES PATIENT FROM MM DO 18. HOSPITALIZATIO FROM LOS OUTSIDE LAB? 22. MEDICAID RESULT CODE 23. PRIOR AUTHORIZES 80 33 13 71 13 71	UNABLE TYY UNABLE TYY NO DATE: AND DATE:	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14. DATE OF CURRENT:	PERSON'S SIGN uest payment of go NESS (First symp IURY (Accident) C EGNANCY(LMP) sician OR OTHER To Plate To Plate To Plate Serv D 02 11 D 02 11 D 02 11	NATURE authoriovernment benefits Storm) OR	Ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR 17a. I.D. NUMBER OF REFERR 2	E OR SIMILAR ILLNESS. The state of the stat	payment of medic	UNABLE de la decembra del decembra de la decembra de la decembra del decembra de la decembra del decembra de la decembra de la decembra de la decembra de la decembra del decembra de la decembra del decembra del decembra de la decem	TO WOR	RK IN CI TO ED TO C S CHAF	URREN MM : CURRE MM : RGES	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: III. III. III. III. III. III. III. II	PERSON'S SIGN uest payment of go NESS (First symp IURY (Accident) C EGNANCY(LMP) sician OR OTHER To Plate To Plate To Plate Serv D 02 11 D 02 11 D 02 11	NATURE authoriovernment benefits Property PROCE C	ize the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAMI GIVE FIRST DATE 117a. LD. NUMBER OF REFERR 17a. LD. NUMBER OF REFERR 2 D DEDURES, SERVICES, OR SUPPL (Explain Unusual Circumstances) HACPCS L MODIFIER 9381 EP 04772 EP 17444	E OR SIMILAR ILLNESS. DO 1 1111 ING PHYSICIAN E DIAGNOSIS CODE	payment of medic	UNABLE OF THE PROPERTY OF THE	TO WOR	RRK IN CIC TO TO S CHAFF	SIGNA SI SIGNA SIGNA SIGNA SI	T OCCUPATION T OCCUPATION T SERVICES DD YY T SERVICES		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: ILL ILL	PERSON'S SIGN uest payment of go NESS (First symp URY (Accident) C EGNANCY(LMP) IILLNESS OR INJU To DD YY DD YY OQ 11	NATURE authoriovernment benefits Storm) OR	Its in release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAM, GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR EMS 1,2,3 OR 4 TO ITEM 24E BY 3	E OR SIMILAR ILLNESS. 10 1 1111 ING PHYSICIAN LINE) E IES DIAGNOSIS CODE	payment of medic services described SIGNED	UNABLE PROPERTY OF THE PROPERT	N ORIG	RK IN CLOTON TO	SIGNA SI SIGNA SIGNA SIGNA SI	T OCCUPATION DD: TY T OCCUPATION DD: TY NT SERVICES DD: TY K RESERVED FC LOCAL USE		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 114 DATE OF CURRENT: III II	PERSON'S SIGN uest payment of go NESS (First symp UPRY (Accident) C EGNANCY (LMP) ilician OR OTHER To Plac DD YY Serv D 02 11 D 02 11 D 02 11 SSN EIN DR SUPPLIER IEDERTIALS	NATURE authoriovernment benefits NOOM OR STATE OR SOURCE URY (RELATE IT CO Type PROCE CO Service PROCE 90 90 90 26 PATIEN 32 NAME A	TES ACCOUNT NO. 22, ACCURATE A SITHER TO A STANCE OF THE ACCURATION OF THE ACCOUNT NO. 22, ACCURATE A SITHER ACCOUNT NO. 22, ACCURATE A SITHER ACCOUNT NO. 22, ACCURATE A SITHER ACCOUNT NO. 22, ACCURATE ACCURAT	E OR SIMILAR ILLNESS. 10 1 1111 ING PHYSICIAN LINE) E IES DIAGNOSIS CODE	payment of medic services described	at benefit of the low	N ORIGEN	RK IN CIC TO	URREN MM CURREN MM CORRES COB	T OCCUPATION DD: TY T OCCUPATION DD: TY NT SERVICES DD: TY K RESERVED FC LOCAL USE		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: MM	PERSON'S SIGN uest payment of go NESS (First symp UFRY (Accident) C EGNANCY (LMP) IICIAN OR OTHER TO Place DD YY S SET D O2 11 O2 11 O2 11 SSN EIN DR SUPPLIER IEDERTIALS the reverol.	NATURE authoriovernment benefits NOOM OR STATE OR SOURCE URY (RELATE IT CO Type PROCE CO Service PROCE 90 90 90 26 PATIEN 32 NAME A	ZE the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR 25. IF PATIENT HAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR MM 17a. I.D. NUMBER OF REFERR MM 17a. I.D. NUMBER OF REFERR PATIENT OF THE P	E OR SIMILAR ILLNESS. 10 1 1111 ING PHYSICIAN LINE) E IES DIAGNOSIS CODE	payment of medic services described	INDICATE OF THE PROPERTY OF TH	N ORIGE PRODUCTION ORIGE PRODUCTION ORIGE PRODUCTION ORIGE PRODUCTION ORIGINAL ORIGI	RISON'S SINDERSON'S SINDERSON'S SINDERSON'S SINDERSON'S SINDERSON'S SINDERSON SINDERSO	URREN MM URREN MM GOB O O O O O O O O O O O O O O O O O O	T OCCUPATION DD: TY T OCCUPATION DD: TY NT SERVICES DD: TY K RESERVED FC LOCAL USE		
12 PATIENT'S OR AUTHORIZET to process this claim. I also red below. SIGNED 14 DATE OF CURRENT: III III	PERSON'S SIGN uest payment of go NESS (First symp UFRY (Accident) C EGNANCY (LMP) IICIAN OR OTHER TO Place DD YY S SET D O2 11 O2 11 O2 11 SSN EIN DR SUPPLIER IEDERTIALS the reverol.	NATURE authoriovernment benefits PROPERTY PROPERTY CONTROL CONTROL PROPERTY CONTROL PROPERTY CONTROL PROPERTY	ZE the release of any medical or oths either to myself or to the party who DATE 15. IF PATIENT HAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR 25. IF PATIENT HAS HAD SAMI GIVE FIRST DATE MM 17a. I.D. NUMBER OF REFERR MM 17a. I.D. NUMBER OF REFERR MM 17a. I.D. NUMBER OF REFERR PATIENT OF THE P	E OR SIMILAR ILLNESS. The state of the stat	payment of medic services described	INDICATE OF THE PROPERTY OF TH	N ORIGE PLANT PLAN	RK IN CIC TO TO TO TO S CHAFT TO TO TO S CHAFT TO TO TO S CHAFT TO	URREN MM URREN MM GOB O O O O O O O O O O O O O O O O O O	T OCCUPATION DD : YY T SERVICES DD : YY NT SERVICES DD : YY K RESERVED F(LOCAL USE		